



Send completed forms to  
DOH Communicable  
Disease Epidemiology  
Fax: 206-418-5515

LHJ Use ID \_\_\_\_\_  
☐ Reported to DOH Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
LHJ Classification ☐ Confirmed  
☐ Probable  
By: ☐ Lab ☐ Clinical  
☐ Other: \_\_\_\_\_  
Outbreak # (LHJ) \_\_\_\_\_ (DOH) \_\_\_\_\_

DOH Use ID \_\_\_\_\_  
Date Received \_\_\_\_/\_\_\_\_/\_\_\_\_  
DOH Classification  
☐ Confirmed  
☐ Probable  
☐ No count; reason: \_\_\_\_\_

# Rabies

County \_\_\_\_\_

## REPORT SOURCE

Initial report date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation  
start date:  
\_\_\_\_/\_\_\_\_/\_\_\_\_

Reporter name \_\_\_\_\_

Reporter phone \_\_\_\_\_

Primary HCP name \_\_\_\_\_

Primary HCP phone \_\_\_\_\_

## PATIENT INFORMATION

Name (last, first) \_\_\_\_\_

Address \_\_\_\_\_ ☐ Homeless

City/State/Zip \_\_\_\_\_

Phone(s)/Email \_\_\_\_\_

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Occupation/grade \_\_\_\_\_

Employer/worksite \_\_\_\_\_ School/child care name \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

## CLINICAL INFORMATION

Onset date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ☐ Derived Diagnosis date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Illness duration: \_\_\_\_\_ days

### Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ Fever Highest measured temp: \_\_\_\_\_ °F  
Type: ☐ Oral ☐ Rectal ☐ Other: \_\_\_\_\_ ☐ Unk

☐ ☐ ☐ ☐ Headache

☐ ☐ ☐ ☐ Malaise

☐ ☐ ☐ ☐ Weakness

☐ ☐ ☐ ☐ Anxiety/apprehension

☐ ☐ ☐ ☐ Pain/sensory changes around location of bite

☐ ☐ ☐ ☐ Excitability

☐ ☐ ☐ ☐ Trouble swallowing, aversion to water (hydrophobia)

☐ ☐ ☐ ☐ Aversion to air flow on face (aerophobia)

### Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Pre-existing wound, animal bite

☐ ☐ ☐ ☐ History of bat exposure

### Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ Encephalitis

☐ ☐ ☐ ☐ Paresis

☐ ☐ ☐ ☐ Paralysis

☐ ☐ ☐ ☐ Delirium

☐ ☐ ☐ ☐ Convulsions

☐ ☐ ☐ ☐ Aerophobia

☐ ☐ ☐ ☐ Hydrophobia

☐ ☐ ☐ ☐ Coma

### Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name \_\_\_\_\_

Admit date \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge date \_\_\_\_/\_\_\_\_/\_\_\_\_

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ ☐ ☐ ☐ Autopsy Place of death \_\_\_\_\_

### Vaccine History

Y N DK NA

☐ ☐ ☐ ☐ Rabies vaccine completed in past (at least 3 doses)

Date of last rabies vaccine: \_\_\_\_/\_\_\_\_/\_\_\_\_

Total # rabies doses: \_\_\_\_\_

### Laboratory

P = Positive O = Other, unknown  
N = Negative NT = Not Tested  
I = Indeterminate

Collection date \_\_\_\_/\_\_\_\_/\_\_\_\_

P N I O NT

☐ ☐ ☐ ☐ ☐ DFA for rabies (clinical specimen, preferably brain or nuchal biopsy)

☐ ☐ ☐ ☐ ☐ Rabies virus culture (saliva, CSF or CNS tissue)

☐ ☐ ☐ ☐ ☐ Rabies antibodies 5 in unvaccinated person (serum or CSF)

Lab submitted to: \_\_\_\_\_

## NOTES

**INFECTION TIMELINE**

Enter onset date/time  
(first sx) in heavy box.  
Count backward to  
determine probable  
exposure period

Weeks from  
onset:

Exposure period\*

- 8 -3

o  
n  
s  
e  
t

Calendar date/time:

\* rarely, may be as short as  
9 days or as long as 7  
years, depending on site  
and severity of wound

**EXPOSURE**

**Y N DK NA**

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or  
outside of usual routine  
Out of: ☐ County ☐ State ☐ Country  
Destinations/Dates: \_\_\_\_\_

Exposure location: \_\_\_\_\_  
Anatomic site of injury or wound (e.g. head, arm):  
\_\_\_\_\_

Circumstances of animal exposure: \_\_\_\_\_

**Y N DK NA**

- ☐ ☐ ☐ ☐ Occupational exposure (e.g. pet shop,  
veterinary clinic, lab worker, wildlife worker)
- ☐ ☐ ☐ ☐ Animal exposure  
Type of animal exposure:  
☐ Bite ☐ Saliva ☐ Scratch  
☐ Bat in house ☐ Bat in sleeping area  
☐ Other: \_\_\_\_\_ ☐ Unk  
Type of animal:  
☐ Bat ☐ Cat ☐ Dog ☐ Ferret ☐ Raccoon  
☐ Other: \_\_\_\_\_ ☐ Unk  
Animal status:  
☐ Domestic ☐ Stray ☐ Wild  
☐ Other: \_\_\_\_\_ ☐ Unk  
Animal description: \_\_\_\_\_  
Breed: \_\_\_\_\_  
Animal name: \_\_\_\_\_

Wound cleaned: ☐ Y ☐ N ☐ DK ☐ NA

Animal exposure provoked: ☐ Y ☐ N ☐ DK ☐ NA

**Y N DK NA**

- ☐ ☐ ☐ ☐ Animal vaccination history known  
Animal rabies vaccination status:  
☐ Unvaccinated or vaccine not current  
☐ Vaccinated ☐ Unk  
Date of (animal) last rabies vaccine: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Total # (animal) rabies doses: \_\_\_\_\_

**Y N DK NA**

- ☐ ☐ ☐ ☐ Animal contact/control information known. If yes:  
Animal owner or location (e.g. park) name: \_\_\_\_\_

Owner or location address: \_\_\_\_\_

Owner or location phone number: \_\_\_\_\_

Veterinary clinic name: \_\_\_\_\_

Clinic address: \_\_\_\_\_

Clinic phone: \_\_\_\_\_

Veterinarian name: \_\_\_\_\_

Animal control contact name: \_\_\_\_\_

Animal control contact phone: \_\_\_\_\_

**Y N DK NA**

- ☐ ☐ ☐ ☐ Injury or exposure circumstances known  
Date of exposure: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Patient could not be interviewed

☐ No risk factors or exposures identified

Most likely exposure/site: \_\_\_\_\_

Site name/address: \_\_\_\_\_

Where did exposure probably occur? ☐ In WA (County: \_\_\_\_\_) ☐ US but not WA ☐ Not in US ☐ Unk

**PATIENT PROPHYLAXIS / TREATMENT**

**Y N DK NA**

- ☐ ☐ ☐ ☐ Treatment recommended  
if yes:  
Human RIG given ☐ Y ☐ N ☐ DK ☐ NA  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ RIG refused

**Y N DK NA**

- ☐ ☐ ☐ ☐ Rabies vaccine given  
Date of initial vaccination: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Vaccine name: \_\_\_\_\_  
Prescribing health care provider: \_\_\_\_\_  
Phone: \_\_\_\_\_  
☐ Vaccination refused

**PUBLIC HEALTH ISSUES**

**Y N DK NA**

- ☐ ☐ ☐ ☐ Animal available for observation or quarantine  
(cat, dog or ferret only)

**PUBLIC HEALTH ACTIONS**

- Animal disposition: ☐ Sent for testing ☐ Under observation  
☐ Healthy after 10 day observation  
☐ Lost to follow-up ☐ Other: \_\_\_\_\_

Quarantine site contact name: \_\_\_\_\_

Quarantine site address: \_\_\_\_\_

Quarantine site phone: \_\_\_\_\_

**NOTES**

Investigator \_\_\_\_\_ Phone/email: \_\_\_\_\_ Investigation complete date \_\_\_\_/\_\_\_\_/\_\_\_\_

Local health jurisdiction \_\_\_\_\_ Record complete date \_\_\_\_/\_\_\_\_/\_\_\_\_